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Community Mental Health Professionals in Italy Report Higher Well-Being than Hospital-Based Outpatient Staff in 2025: A Cross-Sectional Study

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Abstract

Background: COVID-19 increased psychological distress among healthcare workers. Italian studies have suggested lower distress levels among mental health professionals compared to hospital-based colleagues. **Methods:** In May 2025, we conducted a cross-sectional observational study in community mental health centers and non-psychiatric hospital outpatient departments in Sardinia, Italy, involving 101 professionals from three community mental health centers and 97 staff members from four non-psychiatric hospital outpatient departments. The SF-12 was used to assess health-related quality of life (HRQoL) and the PHQ-9 was used to assess depressive symptoms. Results were also compared with pre-pandemic community samples. **Results:** Mental health professionals reported fewer depressive symptoms and better quality of life than hospital-based colleagues: PHQ-9 ≥ 10 : 10.9% vs. 35.0% (11/101 vs. 34/97) (OR = 0.23; 95%CI 0.11–0.47; $p < 0.001$); PHQ-9 ≥ 9 : 14.8% vs. 38.1% (OR = 0.31; 95%CI 0.16–0.60; $p < 0.001$). Mean PHQ-9 score: 4.45 ± 3.51 vs. 8.35 ± 3.95 ($p < 0.001$). Low HRQoL (SF-12 ≤ 36): 34.6% vs. 62.9% (35/101 vs. 61/97) (OR = 0.31; 95%CI 0.19–0.52; $p < 0.001$). No significant within-group differences were found by sex, age, or professional role. Compared with pre-pandemic community data, the well-being of mental health professionals remained stable. Limitations: Cross-sectional design and convenience sampling limit causal inference and generalizability. **Conclusions:** The organizational structure, operational flexibility, and peer collaboration typical of community-based services may contribute to the sustained psychological well-being of mental health professionals. The community-based model deserves consideration for future reforms aimed at improving staff well-being.



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1. Introduction

The COVID-19 pandemic profoundly affected public health and imposed an exceptional burden on healthcare systems worldwide [1]. Numerous studies have documented elevated levels of anxiety, depression, and burnout among healthcare workers during

infectious disease outbreaks, highlighting the vulnerability of this population to prolonged occupational stress [2–5]. The crisis generated major organizational challenges which, combined with excessive workloads and infection risk, led to elevated psychological distress among healthcare workers [6–10]. Most evidence on healthcare workers' mental health has focused on the acute phase of the COVID-19 pandemic, whereas fewer studies have examined longer-term post-pandemic trajectories. In addition, evidence specifically comparing mental health professionals with other healthcare workers remains limited, particularly in community-based service settings.

Italy was among the first Western countries severely affected, with high excess mortality during the initial waves [11,12]. Healthcare professionals paid a particularly heavy toll, both physically and psychologically, with numerous fatalities reported among frontline staff [13,14].

Prior to the pandemic, the Italian National Health Service was widely regarded as robust, yet the emergency exposed significant organizational and resource limitations [14–16]. These shortcomings, together with shortages of personal protective equipment and prolonged workloads, contributed to frustration, helplessness, and feelings of abandonment among many professionals [17,18]. Previous research has also emphasized that organizational factors—such as leadership support, team cohesion, and perceived institutional protection—may play a relevant role in buffering psychological distress among healthcare professionals during public health emergencies [19,20].

During the pandemic, a study conducted at the University Hospital of Cagliari revealed high rates of depressive symptoms and reduced quality of life among outpatient staff working in pain therapy, oncology, dermatology, and cardiology departments, compared to pre-pandemic data collected in the same setting [19]. Conversely, mental health professionals working in community-based services in the same region reported greater job satisfaction and lower distress levels [21].

These observations suggest that hospital-based outpatient staff—exposed to continuous infection risk and reduced social contact—experienced a stronger sense of siege, whereas community mental health professionals, working in smaller and more flexible teams, benefited from peer support networks and hybrid care models that enabled remote contact with patients. Five years after the initial pandemic waves, many healthcare systems continue to deal with the long tail of COVID-19-related organizational strain, including persistent staff shortages, increased administrative burden, and cumulative fatigue. Data were collected in May 2025. Evaluating staff well-being at this time point allows assessment not only of the acute impact of the pandemic but also of longer-term adaptation processes, including potential “organizational recovery,” across different service models.

We hypothesized that employment in community mental health services is associated with higher post-pandemic well-being among professionals, and explored whether this association may be plausibly interpreted in light of organizational features described in the literature.

2. Materials and Methods

2.1. Study Design

This was an observational, cross-sectional study conducted according to the STROBE guidelines and in accordance with the ethical principles of the Declaration of Helsinki [22].

2.2. Study Sample

A voluntary sample was recruited from three community mental health centers in Sardinia (Nuoro, Sanluri, and Cagliari). Participants were contacted and completed the study instruments at their workplace. A cross-sectional comparison was made using the

same instruments completed by healthcare workers from four non-psychiatric hospital outpatient departments, as well as with community samples collected before the COVID-19 pandemic. The sample was convenience-based and region-specific, and therefore not intended to be representative of all Italian healthcare workers. Moreover, community mental health staff were recruited from three local health authorities, whereas hospital outpatient staff were recruited from a single university hospital.

All healthcare professionals present at work during the same week in May 2025 were invited to participate in the study. Data collection took place four morning shifts and three afternoon shifts. Only one doctor, two nurses, and one psychologist declined to participate, citing lack of time due to workload (4.0% of the total invited sample). A total of 101 healthcare workers completed the study instruments and were included in the mental health sample.

A comparison group of 97 healthcare workers from four outpatient departments at the University Hospital of Cagliari was recruited using the same methodology during the same week in May 2025. This comparison group is also the subject of other parallel studies. During the study week, participants in both groups were engaged in outpatient activities only; inpatient responsibilities, night shifts, and on-call duties were not part of the assessed roles.

2.3. Study Instruments

After providing informed consent, healthcare professionals completed the following instruments:

A demographic questionnaire collecting information on age, sex, healthcare facility, and professional role. This form had been used in previous studies [19].

The Italian version of the 12-item Short Form Health Survey (SF-12) [23] was used to assess perceived health-related quality of life (HRQoL). The SF-12 evaluates several domains of well-being, including social functioning, emotional state, general health, vitality, and mental health. Higher total scores indicate better perceived HRQoL. A cut-off score of ≤ 36 was used to identify individuals with low HRQoL, corresponding to one standard deviation below the Italian normative mean [24]. Although the SF-12 is often reported as separate physical and mental component summary scores, in the present study, the SF-12 was analyzed as a single global HRQoL score, as previously applied in Italian population studies. The cutoff of ≤ 36 corresponds to one standard deviation below the Italian normative mean for the total score [24].

The Patient Health Questionnaire-9 (PHQ-9) [24,25], in its validated Italian version [26,27], was used to screen for current depressive symptoms. This self-administered questionnaire includes nine items based on DSM-5 criteria [28,29], with total scores ranging from 0 to 27. Two cut-offs were applied: ≥ 10 (widely accepted in the international literature) and ≥ 9 (previously used in healthcare worker studies [19]), the latter favoring higher sensitivity to avoid false negatives). The primary outcomes were (i) the prevalence of clinically relevant depressive symptoms based on PHQ-9 cut-offs (≥ 10 and ≥ 9), and (ii) the prevalence of low HRQoL, defined as SF-12 total score ≤ 36 . Secondary outcomes included mean PHQ-9 and SF-12 scores and subgroup comparisons by sex, age category, and professional role.

2.4. Statistical Analysis

A cross-sectional comparison was conducted between community mental health workers and hospital-based outpatient staff using PHQ-9 and SF-12 scores. Two PHQ-9 thresholds (≥ 9 and ≥ 10) were used to assess depressive symptoms, consistent with previous studies [19,29,30]. Questionnaires with incomplete PHQ-9 or SF-12 items were

checked at collection; no questionnaires required imputation and analyses were performed on complete cases.

Differences in proportions were analyzed using the χ^2 test. Odds ratios (ORs) and 95% confidence intervals (CIs) were computed using the Miettinen–Nurminen method. Group means were compared using one-way ANOVA with $F(1,196)$ and two-tailed significance at $p < 0.05$.

Low HRQoL was defined as an SF-12 score ≤ 36 , consistent with Italian normative data [24]. PHQ-9 and SF-12 results were also compared with pre-pandemic community samples [24,31]. Where applicable, direct standardization for age and sex was used to adjust for population differences. For comparisons with pre-pandemic community samples, age- and sex-standardization was applied to improve comparability. However, given differences in time periods, sampling frames, and study populations, these comparisons were considered exploratory and intended to provide contextual rather than definitive evidence of stability or change in well-being. Primary outcomes were predefined as PHQ-9 ≥ 10 and SF-12 ≤ 36 . Subgroup and alternative cutoff analyses were considered exploratory and were not corrected for multiple comparisons.

3. Results

3.1. Sample Characteristics

Table 1 summarizes the demographic and professional characteristics of the study samples. The two groups were comparable in terms of sex and age (<50 vs. ≥ 50 years), with no statistically significant differences. However, medical doctors were significantly underrepresented among community mental health professionals (13.9%) compared with hospital-based outpatient staff (36.1%; $\chi^2(1) = 13.12$, $p < 0.001$). Overall, the sample reflected the staffing composition of the participating services, with a predominance of non-physician roles. The distribution of sex and age categories was comparable across groups, supporting the between-group comparisons on the main outcomes.

Table 1. Personal and professional characteristics of the sample.

Sample	Health Workers Mental Health (101) N(%)	Health Workers Non Mental Health (97) N(%)	χ^2 (1)
Gender Men	22 (21.8%)	29 (29.9%)	1.704 $p = 0.192$
≥ 50	42 (41.6%)	36 (37.1%)	0.414 $p = 0.520$
Medical Doctors (MD)	14 (13.9%)	35 (36.1%)	13.119 $p < 0.001$
Non-MD (Nurses)	19 (18.8%)	31 (32.0%)	
Non-MD (Psychologists)	13 (12.9%)	-	
Non-MD (Social Workers)	4 (4.0%)	-	
Non-MD (Rehabilitation Workers)	18 (17.8%)	-	
Non-MD (Others)	33 (32.7%)	35 (36.1%)	

Note: Detailed non-MD professional categories are reported descriptively; inferential testing across all categories was not performed due to sparse cell counts.

3.2. Depressive Symptoms and Quality of Life

Table 2 presents the prevalence of depressive symptoms and low perceived health-related quality of life (HRQoL) in the two groups.

Table 2. Frequency of depression and quality of life in mental health workers compared with non-psychiatric health service workers.

Score	Research Sample Mental Health	Research Sample Non Mental Health	Stat	<i>p</i>	OR (CI95%)
Score PHQ-9 \geq 10	11 (10.9%)	34 (35.0%)	χ^2 (1) = 18.108	<i>p</i> < 0.001	0.23 (0.1–0.4)
Score PHQ-9 \geq 9	15 (14.8%)	37 (38.1%)	χ^2 (1) = 11.921	<i>p</i> < 0.001	0.31 (0.1–0.6)
Score PHQ9 Mean \pm SD	4.45 \pm 3.51	8.35 \pm 3.95	Anova F (1.196) = 54.035	<i>p</i> < 0.001	-
Score SF-12 \leq 36	35 (34.6%)	61 (62.9%)	χ^2 (1) = 15.791	<i>p</i> < 0.001	0.31 (0.2–0.6)
Score SF-12 Mean \pm SD	37.56 \pm 5.43	32.98 \pm 7.16	F (1.196) = 25.85	<i>p</i> < 0.001	-

Mental health professionals reported significantly lower depressive symptoms and higher HRQoL compared with hospital-based outpatient staff. Using the PHQ-9 \geq 10 threshold, depressive symptoms were detected in 10.9% of community mental health professionals and in 35.0% of hospital-based outpatient staff (OR = 0.23; 95% CI: 0.11–0.47; *p* < 0.001). When applying the more sensitive cut-off (PHQ-9 \geq 9), the difference remained significant (14.8% vs. 38.1%; OR = 0.31; 95% CI: 0.16–0.60; *p* < 0.001).

Mean PHQ-9 scores were also significantly lower among community mental health professionals (4.45 \pm 3.51) than among hospital-based outpatient staff (8.35 \pm 3.95; F (1.196) = 54.04; *p* < 0.001).

Regarding HRQoL, 34.6% of community mental health professionals reported low perceived quality of life (SF-12 \leq 36) compared with 62.9% of hospital-based outpatient staff (OR = 0.31; 95% CI: 0.19–0.52; *p* < 0.001). The mean SF-12 score was significantly higher among community mental health professionals (37.56 \pm 5.43 vs. 32.98 \pm 7.16; F (1.196) = 25.85; *p* < 0.001), indicating overall better perceived well-being.

3.3. Subgroup Analyses

Table 3 reports subgroup analyses comparing depressive symptoms and low HRQoL between community mental health professionals and hospital-based outpatient staff, stratified by sex, age, and professional role.

Sex: Among women, community mental health professionals reported lower rates of both depressive symptoms (13.9% vs. 38.2%; *p* < 0.001) and low HRQoL (35.4% vs. 70.6%; *p* < 0.001). Among men, no statistically significant differences were observed between the two groups.

Age: For participants aged \geq 50 years, community mental health professionals showed a lower prevalence of depressive symptoms (11.9% vs. 36.1%; *p* = 0.011), although the difference in HRQoL did not reach statistical significance. Among those aged < 50 years, depressive symptoms (16.9% vs. 39.3%; *p* = 0.006) and low HRQoL (33.9% vs. 67.2%; *p* < 0.001) were both significantly less frequent in the community mental health group.

Professional role: No significant differences were found among medical doctors. However, among non-physician professionals, depressive symptoms (12.6% vs. 46.8%; *p* < 0.001) and low HRQoL (35.6% vs. 69.3%; *p* < 0.001) were significantly lower among community mental health professionals.

Table 3. Comparison of the frequency of screening-level depressive symptoms (PHQ9 \geq 9) and of people with low perception of quality of life (SF-12 \leq 36) in mental health workers and professionals of non-psychiatric care services in relation to subgroups distinguished by sex, age (<50; \geq 50) and profession (medical doctors, other professionals).

Sample	PHQ-9 \geq 9	χ^2 (1), <i>p</i>	OR (NMH) (CI95%)	SF12 \leq 36	χ^2 (1), <i>p</i>	OR (NMH) (CI95%)
Gender women Non MH	26/68 (38.2%)	=14.082 <i>p</i> < 0.001	4.45 (2.0–4.09)	48/68 (70.6%)	=18.076 <i>p</i> < 0.001	4.37 (2.2–8.8)
Gender women MH	11/79 (13.9%)	-	-	28/79 (35.4%)	-	-
Gender men Non MH	11/29 (37.9%)	=2.187 <i>p</i> = 0.139	2.78 (0.7–11.2)	13/29 (44.8%)	=0.888 <i>p</i> = 0.346	1.74 (0.5–5.5)
Gender men MH	3/22 (13.6%)	-	-	7/22 (31.8%)	-	-
\geq 50 years Non MH	13/36 (36.11%)	=6.399 <i>p</i> = 0.011	4.18 (1.3–13.3)	20/36 (55.5%)	=3.085 <i>p</i> = 0.079	2.25 (0.9–5.6)
\geq 50 years MH	5/42 (11.9%)	-	-	15/42 (35.7%)	-	-
<50 years Non MH	24/61 (39.3%)	=7.408 <i>p</i> = 0.006	3.18 (1.3–7.4)	41/61 (67.2%)	=13.319 <i>p</i> < 0.001	4.00 (1.9–8.5)
<50 years MH	10/59 (16.9%)	-	-	20/59 (33.9%)	-	-
MD-Non MH	8/35 (22.6%)	=0.177 <i>p</i> = 0.674	0.74 (0.2–3.0)	18/35 (51.4%)	=2.112 <i>p</i> = 0.146	2.67 (0.7–10.1)
MD-MH	4/14 (28.6%)	-	-	4/14 (28.6%)	-	-
Non MD-Non MH	29/62 (46.8%)	=21.473 <i>p</i> < 0.001	6.07 (2.7–13.6)	43/62 (69.3%)	=16.468 <i>p</i> < 0.001	4.09 (2.0–8.2)
Non MD-MH	11/87 (12.6%)	-	-	31/87 (35.6%)	-	-

3.4. Within-Group Comparisons

Table 4 presents within-group comparisons among community mental health professionals by sex, age, and professional role. No statistically significant differences were found in depressive symptoms or HRQoL across any subgroup (all *p* > 0.05).

Table 4. Depressive Symptoms and Low H-QoL comparing by sex, age and professional role in the sample of health workers of mental health services.

Subgroup	N	PHQ-9 \geq 9 n (%)	χ^2 , <i>p</i> , OR, (CI95%)	SF-12 \leq 36 n (%)	χ^2 , <i>p</i> , OR, (CI95%)
Women	79	11 (13.9%)	Yates 0.001 <i>p</i> = 0.999	28 (35.4%)	Yates 0.100 <i>p</i> = 0.752
Men	22	3 (13.6%)	OR(W) = 1.02 (0.3–4.0)	7 (31.8%)	OR(W) = 1.18 (0.4–3.3)
<50 years	59	10 (16.9%)	Yates 1.272 <i>p</i> = 0.259	20 (33.9%)	Yates 0.097 <i>p</i> = 0.755
\geq 50 years	42	5 (11.9%)	OR(<50) = 1.92 (0.6–6.0)	15 (35.7%)	OR(<50) = 1.19 (0.4–3.6)
MD	14	4 (28.6%)	Yates 1.277 <i>p</i> = 0.258	4 (28.6%)	Yates 0.045 <i>p</i> = 0.832
Non-MD	87	11 (12.6%)	OR(NMD) = 0.37 (0.1–1.4)	31 (35.6%)	OR(NMD) = 1.38 (0.4–4.8)

Note: No statistically significant differences were observed within the community mental health group across sex, age category, or professional role (all *p* > 0.05).

3.5. Comparison with Pre-Pandemic Samples

Table 5 compares the community mental health professionals with pre-pandemic community samples from Sardinia and Italy. The prevalence of depressive symptoms did not differ significantly from the general Sardinian population [31] and should also be interpreted in light of the broader epidemiological background of depressive disorders and antidepressant use in Italy [32]. The proportion of individuals with low HRQoL was slightly higher than in the Italian normative sample [24], but this difference was not statistically significant. These historical comparisons should be interpreted with caution. Differences in socio-economic context, healthcare system strain, and response patterns across time periods may introduce biases that cannot be fully addressed through demographic standardization alone. Accordingly, the absence of significant differences should not be interpreted as definitive evidence of unchanged well-being, but rather as suggestive of relative stability within the limits of the available data.

Table 5. Depressive Symptoms and Low H-QoL in the study samples of health professionals of mental health facilities in comparison with two normative community samples.

	Research Sample	Normative Sample	Chi Square 1 df–P–Post vs. Pres	OR (95% df) Post vs. Pre
Score PHQ-9 > 8	15 (14.8%)	97 (13.1%) *	-	-
Score PHQ-9 > 8 (after direct standardization against normative sample)	14 (13.9%)	97 (13.1%) *	=0.044 P = 0.834	1.07 (0.6–1.9)
Score SF-12 ≤ 36	35 (34.6%)	606 (25.9%) **	-	-
Score SF-12 ≤ 36 (after direct standardization against normative sample)	33 (32.7%)	606 (25.9%) **	=2.300 P = 0.128	1.40 (0.9–2.1)

* Moro et al. 2015; [31] ** Carta et al. 2012 [24].

4. Discussion

This study provides new evidence that community mental health professionals in Sardinia have maintained significantly better psychological well-being and higher perceived quality of life than their colleagues working in hospital-based outpatient services, even five years after the acute phase of the COVID-19 pandemic. The consistency of this finding across multiple indicators—lower depressive symptoms and higher HRQoL observed several years after the acute phase of the COVID-19 pandemic—indicates a stable association between service setting and professional well-being. However, given the cross-sectional design, these findings should be interpreted as descriptive associations rather than evidence of causal effects.

Given the cross-sectional design, no causal inferences can be drawn, and the observed differences should be interpreted descriptively. While these patterns may be consistent with differences in organizational context, the specific organizational mechanisms potentially underlying these associations (e.g., exposure profiles, organizational culture, operational flexibility) were not directly measured in the present study and therefore remain hypothetical.

These results resonate with earlier studies showing that professionals in mental health services reported higher job satisfaction and lower emotional exhaustion than those employed in general hospital departments during the pandemic [19,21]. More broadly, the literature on occupational mental health during epidemic crises suggests that institutional

support and team-based organizational structures may mitigate stress responses among healthcare workers [5,33]. They also confirm international data highlighting the profound and prolonged psychological impact of COVID-19 on healthcare workers [12,34–38]. A distinctive aspect of our findings is that the advantage observed among community mental health professionals has endured over time, suggesting not only short-term resilience but also sustained adaptation.

Several structural and cultural elements may be hypothesized to underlie this difference, although they were not directly assessed in the present study. Importantly, these organizational characteristics were not directly measured in the present study. Therefore, the proposed interpretations should be regarded as theoretical explanations derived from the literature rather than empirically tested mechanisms. In Sardinia—as in other Italian regions—community mental health services operate through small, multidisciplinary teams that emphasize flexibility, shared decision-making, and close peer collaboration [39–43]. This model may be associated with a greater sense of belonging and perceived control; however, such potential buffering effects remain speculative and cannot be tested within the present design. The capacity to integrate in-person and remote modalities of care may have further reduced perceived isolation and workload pressure [40–44]. In contrast, hospital-based outpatient services, often organized in larger and more hierarchical structures, faced higher exposure to infection risk and greater administrative rigidity, both known sources of burnout [5,20,33]. Alternative explanations should also be considered. Professional self-selection, differences in caseload mix, and unmeasured workplace variables (e.g., leadership style, staffing ratios, or overtime) may have contributed to the observed pattern. In addition, the underrepresentation of medical doctors in the community mental health group may have influenced group-level estimates. Because the study was not powered for multivariable adjustment and several relevant occupational variables were not collected (e.g., years of service, shift patterns, workload indicators), residual confounding cannot be excluded.

Nonetheless, this finding should be interpreted in the context of a national mental health system currently under strain [44–47]. Despite its internationally recognized community-based orientation—rooted in the legacy of the Basaglia reform—Italy’s mental health system has undergone progressive defunding and resource erosion [40,42,46]. The resilience of mental health professionals observed here may thus represent not only the strength of an organizational model but also the personal and ethical commitment of workers operating under increasing systemic fragility. This paradox—high well-being despite institutional scarcity—deserves close attention, as it may not be indefinitely sustainable. In Italy, the community-based mental health model is characterized by multidisciplinary teams and territorial continuity of care. In regions such as Sardinia, where geographic dispersion can influence service organization, team-based flexibility and peer coordination may be particularly relevant determinants of occupational well-being.

Subgroup analyses suggested that the association between working in community mental health settings and better well-being indicators was more pronounced among women and younger staff, groups often considered more vulnerable to psychological distress during crises [3,9,13,18,48]. However, these subgroup analyses were exploratory and not powered for formal interaction testing. Estimates in smaller strata, particularly among men and physicians, were characterized by limited precision, and non-significant findings in these groups should not be interpreted as evidence of absence of association. Accordingly, subgroup patterns should be interpreted cautiously and regarded as hypothesis-generating rather than confirmatory. At the same time, a proportion of mental health professionals reported subthreshold depressive symptoms. This finding should be interpreted cautiously, as the PHQ-9 captures symptoms over a limited two-week time frame and does not allow

characterization of longitudinal patterns. Conceptual models such as Dysregulation of Mood, Energy, and Social Rhythms Syndrome (DYMERS) [49,50] or Recurrent Brief Depression [51–53] are mentioned here solely as theoretical frameworks that may inform future longitudinal research, and not as conditions identified or supported by the present data.

Future research will explore this hypothesis by integrating indicators of biological rhythm regulation and activity patterns, in line with recent proposals on mood spectrum vulnerability [1,50].

The comparison with pre-pandemic community data further strengthens the interpretation of a stable well-being profile among mental health professionals. These findings are suggestive of relative comparability with historical community estimates, within the limits of cross-study comparisons. This pattern underscores the adaptive potential embedded in community-based organizational structures, where flexibility, autonomy, and interpersonal connectedness may operate as enduring resilience mechanisms. From an organizational perspective, the results suggest that relatively low-cost interventions—such as strengthening multidisciplinary team meetings, enhancing peer consultation routines, and increasing decision latitude at the unit level—may represent pragmatic levers to support staff well-being, especially in outpatient settings where administrative burden and time pressure are prominent.

From a methodological perspective, an additional consideration concerns the use of the SF-12. While the SF-12 total score provides a global indicator of perceived health-related quality of life, it does not allow disentangling mental from physical health components. The observed differences are therefore likely driven primarily by mental domains, and future analyses using SF-12 MCS and PCS scores may offer more granular insight into the nature of these associations. In the present study, the SF-12 was analyzed as a single global HRQoL indicator using a raw total score. Although this approach differs from the conventional PCS and MCS scoring, it was adopted to provide a pragmatic summary measure of overall perceived health in this exploratory comparison.

Overall, our findings contribute to the growing recognition that features of healthcare systems, alongside individual coping strategies, are associated with professional well-being. In this perspective, community-based mental health services may represent a paradigmatic context in which organizational characteristics are correlated with more favorable well-being profiles. However, the present cross-sectional data do not allow causal inferences, and the extent to which specific aspects of organizational design contribute to psychological well-being remains to be tested in longitudinal and mechanistic studies.

5. Limitations

The cross-sectional design precludes causal inference and cannot disentangle whether service model characteristics caused higher well-being or whether individuals with higher well-being were more likely to work (or remain) in community mental health settings. The sample was voluntary and region-specific, potentially limiting generalizability to other Italian regions or healthcare systems. Outcomes were based on self-report screening instruments rather than clinical interviews. Finally, we did not collect detailed occupational variables (e.g., workload indicators, shift patterns, overtime, staffing ratios, or leadership measures) that could explain additional variance. In addition, community mental health staff were recruited from three local health authorities, whereas hospital outpatient staff were recruited from a single university hospital; differences in institutional governance and management culture may have contributed to the observed results. Consequently, participants were nested within specific institutional contexts, and potential clustering effects could not be formally modeled due to the limited number of participating sites. Part of the observed differences may therefore reflect setting-level factors rather than

purely individual-level characteristics. Accordingly, any interpretation of organizational ‘protective’ features should be considered hypothesis-generating rather than demonstrative.

Given the number of subgroup analyses, results should be interpreted cautiously, as *p*-values were not adjusted for multiple testing.

6. Conclusions

This study supports the hypothesis that mental health professionals working in community settings maintain higher psychological well-being and quality of life than their hospital-based counterparts in the post-pandemic period. The observed pattern may reflect, rather than directly demonstrate, the influence of structural and cultural organizational characteristics such as small multidisciplinary teams, flexible work organization, and peer collaboration.

These results highlight the broader value of Italy’s community-based mental health model, even amid funding reductions and systemic pressures, without implying superiority over alternative organizational models. Strengthening decentralized, team-oriented, and participatory forms of care may represent a key strategy for safeguarding healthcare workers’ mental health and sustaining service quality.

From a policy standpoint, our findings underscore that well-being and service effectiveness are mutually reinforcing dimensions. Investing in organizational environments that promote cooperation and autonomy is not only ethically desirable but also essential for the sustainability of healthcare systems. Future longitudinal and translational research should clarify the specific mechanisms—psychological, social, and neurobiological—underpinning professional resilience in community settings. Incorporating objective markers of work organization (e.g., staffing ratios, turnover, overtime) alongside standardized psychosocial work environment measures would help identify modifiable determinants of well-being. Multi-site longitudinal designs could clarify whether strengthening team-based community-like organizational features improves outcomes in hospital outpatient settings.

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Abbreviations

The following abbreviations are used in this manuscript:

HRQoL	Health-Related Quality of Life
PHQ-9	Patient Health Questionnaire-9
SF-12	12-Item Short Form Health Survey
DYMERS	Dysregulation of Mood, Energy, and Social Rhythms Syndrome
NHS	National Health Service

References

1. Carta, M.G.; Orrù, G.; Littera, R.; Firinu, D.; Chessa, L.; Cossu, G.; Primavera, D.; Del Giacco, S.; Tramontano, E.; Manocchio, N.; et al. Comparing the Responses of Countries and National Health Systems to the COVID-19 Pandemic: A Critical Analysis with a Case-Report Series. *Eur. Rev. Med. Pharmacol. Sci.* **2023**, *27*, 7868–7880. [CrossRef]
2. Greenberg, N.; Docherty, M.; Gnanapragasam, S.; Wessely, S. Managing mental health challenges faced by healthcare workers during COVID-19 pandemic. *BMJ* **2020**, *368*, m1211. [CrossRef] [PubMed]
3. Lai, J.; Ma, S.; Wang, Y.; Cai, Z.; Hu, J.; Wei, N.; Wu, J.; Du, H.; Chen, T.; Li, R.; et al. Factors Associated with Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Netw. Open* **2020**, *3*, e203976. [CrossRef] [PubMed] [PubMed Central]
4. Serrano-Ripoll, M.J.; Meneses-Echavez, J.F.; Ricci-Cabello, I.; Fraile-Navarro, D.; Fiol-deRoque, M.A.; Pastor-Moreno, G.; Castro, A.; Ruiz-Pérez, I.; Zamanillo Campos, R.; Gonçalves-Bradley, D.C. Impact of viral epidemic outbreaks on mental health of healthcare workers: A rapid systematic review and meta-analysis. *J. Affect. Disord.* **2020**, *277*, 347–357. [CrossRef] [PubMed] [PubMed Central]
5. Shanafelt, T.; Ripp, J.; Trockel, M. Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic. *JAMA* **2020**, *323*, 2133–2134. [CrossRef] [PubMed]
6. Sun, P.; Wang, M.; Song, T.; Wu, Y.; Luo, J.; Chen, L.; Yan, L. The psychological impact of COVID-19 pandemic on health care workers: A systematic review and meta-analysis. *Front. Psychol.* **2021**, *12*, 626547. [CrossRef]
7. Craddock, N.; Sklar, P. Genetics of Bipolar Disorder. *Lancet Lond. Engl.* **2013**, *381*, 1654–1662. [CrossRef] [PubMed]
8. Chirico, F.; Ferrari, G.; Nucera, G.; Szarpak, L.; Crescenzo, P.; Ilesanmi, O. Prevalence of anxiety, depression, burnout syndrome, and mental health disorders among healthcare workers during the COVID-19 pandemic: A rapid umbrella review of systematic reviews. *J. Health Soc. Sci.* **2021**, *6*, 209–220.
9. Rossi, R.; Socci, V.; Jannini, T.B.; Pacitti, F.; Siracusano, A.; Rossi, A.; Di Lorenzo, G. Mental Health Outcomes Among Italian Health Care Workers During the COVID-19 Pandemic. *JAMA Netw. Open* **2021**, *4*, e2136143. [CrossRef]
10. Franzoi, I.G.; Granieri, A.; Sauta, M.D.; Agnesone, M.; Gonella, M.; Cavallo, R.; Lochner, P.; Bragazzi, N.L.; Naldi, A. Anxiety, Post-Traumatic Stress, and Burnout in Health Professionals during the COVID-19 Pandemic: Comparing Mental Health Professionals and Other Healthcare Workers. *Healthcare* **2021**, *9*, 635. [CrossRef]
11. Johns Hopkins University. COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE). Available online: <https://coronavirus.jhu.edu/> (accessed on 22 January 2026).
12. Dorrucchi, M.; Minelli, G.; Boros, S.; Manno, V.; Prati, S.; Battaglini, M.; Corsetti, G.; Andrianou, X.; Riccardo, F.; Fabiani, M.; et al. Excess Mortality in Italy During the COVID-19 Pandemic: Assessing the Differences Between the First and the Second Wave, Year 2020. *Front. Public Health* **2021**, *9*, 669209. [CrossRef]
13. Moro, M.F.; Calamandrei, G.; Poli, R.; Di Mattei, V.; Perra, A.; Kurotschka, P.K.; Restrepo, A.; Romano, F.; La Torre, G.; Preti, E.; et al. The Impact of the COVID-19 Pandemic on the Mental Health of Healthcare Workers in Italy: Analyzing the Role of Individual and Workplace-Level Factors in the Reopening Phase After Lockdown. *Front. Psychiatry* **2022**, *13*, 867080. [CrossRef]
14. Carpiello, B.; Tusconi, M.; di Sciascio, G.; Zanalda, E.; di Giannantonio, M.; Executive Committee of the Italian Society of Psychiatry. Mental health services in Italy during the COVID-19 pandemic. *Psychiatry Clin. Neurosci.* **2020**, *74*, 442–443. [CrossRef] [PubMed] [PubMed Central]
15. La Sanità Italiana è Davvero «Un'eccezione Mondiale»? Available online: <https://pagellapolitica.it/fact-checking/la-sanita-italiana-e-davvero-uneccellenza-mondiale> (accessed on 3 October 2025).
16. Barili, E.; Bertoli, P.; Grembi, V.; Rattini, V. Job Satisfaction among Healthcare Workers in the Aftermath of the COVID-19 Pandemic. *PLoS ONE* **2022**, *17*, e0275334. [CrossRef]

17. Caimmi, P.P.; Capponi, A.; Leigheb, F.; Occo, F.D.; Sacco, R.; Minola, M.; Kapetanakis, E.I. The Hard Lessons Learned by the COVID-19 Epidemic in Italy: Rethinking the Role of the National Health Care Service? *J. Epidemiol. Glob. Health* **2021**, *11*, 266–270. [[CrossRef](#)]
18. Lasalvia, A.; Bonetto, C.; Porru, S.; Carta, A.; Tardivo, S.; Bovo, C.; Ruggeri, M.; Amaddeo, F. Psychological Impact of COVID-19 Pandemic on Healthcare Workers in a Highly Burdened Area of North-East Italy. *Epidemiol. Psychiatr. Sci.* **2020**, *30*, e1. [[CrossRef](#)] [[PubMed](#)]
19. Carta, M.G.; Preti, A.; Portoghese, I.; Pisanu, E.; Moro, D.; Pintus, M.; Pintus, E.; Perra, A.; D'Oca, S.; Atzeni, M.; et al. Risk for Depression, Burnout and Low Quality of Life Among Personnel of a University Hospital in Italy Is a Consequence of the Impact One Economic Crisis in the Welfare System? *Clin. Pract. Epidemiol. Ment. Health* **2017**, *13*, 156–167. [[CrossRef](#)] [[PubMed](#)]
20. West, C.P.; Dyrbye, L.N.; Shanafelt, T.D. Physician burnout: Contributors, consequences and solutions. *J. Intern. Med.* **2018**, *283*, 516–529. [[CrossRef](#)] [[PubMed](#)]
21. Carta, M.G.; Moro, M.F.; Sancassiani, F.; Ganassi, R.; Melis, P.; Perra, A.; Cossu, G. Respect for service users' human rights, job satisfaction, and wellbeing are higher in mental health workers than in other health workers: A study in Italy at time of the Covid pandemic. *J. Public Health Res.* **2022**, *11*, 22799036221107060. [[CrossRef](#)]
22. World Medical Association. World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *JAMA* **2013**, *310*, 2191–2194. [[CrossRef](#)] [[PubMed](#)]
23. Ruotolo, I.; Berardi, A.; Sellitto, G.; Panuccio, F.; Polimeni, A.; Valente, D.; Galeoto, G. Criterion Validity and Reliability of SF-12 Health Survey Version 2 (SF-12v2) in a Student Population during COVID-19 Pandemic: A Cross-Sectional Study. *Depress. Res. Treat.* **2021**, *2021*, 6624378. [[CrossRef](#)]
24. Carta, M.G.; Aguglia, E.; Caraci, F.; Dell'Osso, L.; Di Sciascio, G.; Drago, F.; Del Giudice, E.; Faravelli, C.; Hardoy, M.C.; Lecca, M.E.; et al. Quality of Life and Urban/Rural Living: Preliminary Results of a Community Survey in Italy. *Clin. Pract. Epidemiol. Ment. Health* **2012**, *8*, 169–174. [[CrossRef](#)]
25. Spitzer, R.L.; Kroenke, K.; Williams, J.B. Validation and Utility of a Self-Report Version of PRIME-MD: The PHQ Primary Care Study. Primary Care Evaluation of Mental Disorders. *Patient Health Quest. JAMA* **1999**, *282*, 1737–1744. [[CrossRef](#)]
26. Kroenke, K.; Spitzer, R.L.; Williams, J.B. The PHQ-9: Validity of a Brief Depression Severity Measure. *J. Gen. Intern. Med.* **2001**, *16*, 606–613. [[CrossRef](#)]
27. Rizzo, R.; Piccinelli, M.; Mazzi, M.A.; Bellantuono, C.; Tansella, M. The Personal Health Questionnaire: A New Screening Instrument for Detection of ICD-10 Depressive Disorders in Primary Care. *Psychol. Med.* **2000**, *30*, 831–840. [[CrossRef](#)]
28. Mazzotti, E.; Fassone, G.; Picardi, A.; Sagoni, E.; Ramieri, L.; Lega, I.; Camaioni, D.; Dabeni, D.; Pasquini, P. Il Patient Health Questionnaire (PHQ) per Lo Screening Dei Disturbi Psichiatrici: Uno Studio Di Validazione Nei Confronti Della Intervista Clinica Strutturata per Il DSM-IV Asse I (SCID-I). *J. Psychopathol.* **2003**, *9*, 235–242.
29. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, 5th ed.; American Psychiatric Association: Arlington, TX, USA, 2013.
30. Balestrieri, M.; Carta, M.G.; Leonetti, S.; Sebastiani, G.; Starace, F.; Bellantuono, C. Recognition of Depression and Appropriateness of Antidepressant Treatment in Italian Primary Care. *Soc. Psychiatry Psychiatr. Epidemiol.* **2004**, *39*, 171–176. [[CrossRef](#)] [[PubMed](#)]
31. Moro, M.F.; Angermeyer, M.C.; Matschinger, H.; Holzinger, A.; Piras, A.P.; Cutrano, F.; Mura, G.; Carta, M.G. Whom to Ask for Professional Help in Case of Major Depression? Help-Seeking Recommendations of the Sardinian Public. *Adm. Policy Ment. Health* **2015**, *42*, 704–713. [[CrossRef](#)] [[PubMed](#)]
32. Carta, M.G.; Aguglia, E.; Bocchetta, A.; Balestrieri, M.; Caraci, F.; Casacchia, M.; Dell'osso, L.; Sciascio, G.D.; Drago, F.; Faravelli, C.; et al. The Use of Antidepressant Drugs and the Lifetime Prevalence of Major Depressive Disorders in Italy. *Clin. Pract. Epidemiol. Ment. Health* **2010**, *6*, 94–100. [[CrossRef](#)]
33. Maunder, R.G.; Lancee, W.J.; Balderson, K.E.; Bennett, J.P.; Borgundvaag, B.; Evans, S.; Fernandes, C.M.; Goldbloom, D.S.; Gupta, M.; Hunter, J.J.; et al. Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. *Emerg. Infect. Dis.* **2006**, *12*, 1924–1932. [[CrossRef](#)] [[PubMed](#)] [[PubMed Central](#)]
34. Cossu, G.; Zreik, T.; Ciccu, S.; Guttman, M.E.; Sancassiani, F.; Melis, P.; Angermeyer, M.; Carta, M.G. Respects of Human Rights and Perception of Quality of Care, the Users' Point of View Comparing Mental Health and Other Health Facilities in a Region of Italy. *Int. Rev. Psychiatry Abingdon Engl.* **2023**, *35*, 194–200. [[CrossRef](#)]
35. Bourmistrova, N.W.; Solomon, T.; Braude, P.; Strawbridge, R.; Carter, B. Long-Term Effects of COVID-19 on Mental Health: A Systematic Review. *J. Affect. Disord.* **2022**, *299*, 118–125. [[CrossRef](#)] [[PubMed](#)]
36. Chupanich, P.; Aotprapai, P.; Seesophon, S.; Laoraksawong, P. Factors Associated with Stress among Healthcare Personnel after COVID-19 in Northeast Thailand: A Cross-Sectional Study. *Clin. Pract. Epidemiol. Ment. Health* **2024**, *20*, e17450179327231. [[CrossRef](#)] [[PubMed](#)]
37. Molina, J.D.; Amigo, F.; Vilagut, G.; Mortier, P.; Muñoz-Ruiperez, C.; Rodrigo Holgado, I.; Juanes González, A.; Combarro Ripoll, C.E.; Alonso, J.; Rubio, G. Impact of COVID-19 First Wave on the Mental Health of Healthcare Workers in a Front-Line Spanish Tertiary Hospital: Lessons Learned. *Sci. Rep.* **2024**, *14*, 8149. [[CrossRef](#)]

38. Caramello, V.; Gariglio, V.; Di Salvo, G.; Maina, G.; Boccuzzi, A. Longitudinal Assessment of Mental Health Consequences of the COVID-19 Pandemic Long-Term Exposure on Health Care Workers from a North West Italian Hospital. *Disaster Med. Public Health Prep.* **2023**, *17*, e378. [CrossRef]
39. Aviles Gonzalez, C.I.; De Matteis, S.; Abarca Arias, Y.M.; Cerchiaro Fernandez, D.M.; Guerra Munoz, M.E.; Kalcev, G.; Galletta, M.; Pinna, M.R.; Ramirez, R.R.; Brascesco, M.V.; et al. Are Nurses Working in Mental Health in a Time of Changing Approaches More Exposed to Stress than Other Professionals? Job Satisfaction and Perception of Respect for the Rights of Users in Seven Different Countries Worldwide. *Clin. Pract. Epidemiol. Ment. Health* **2024**, *20*, e17450179349117. [CrossRef]
40. Mezzina, R.; Saraceno, B.; Sashidharan, S. Franco Basaglia (1924–1980): The Reformer of the Italian Psychiatric System: Commentary, Mezzina et al. *Br. J. Psychiatry* **2025**, *227*, 582–583. [CrossRef] [PubMed]
41. Zgueb, Y.; Preti, A.; Perra, A.; El-Astal, S.; Aviles Gonzalez, C.I.; Piras, M.; Testa, G.; Kirolov, I.; Tamburini, G.; Ouali, U.; et al. Staff Perception of Respect for Human Rights of Users and Organizational Well-Being: A Study in Four Different Countries of the Mediterranean Area. *Clin. Pract. Epidemiol. Ment. Health* **2020**, *16*, 109–114. [CrossRef] [PubMed]
42. Barbui, C.; Papola, D.; Saraceno, B. The Italian Mental Health-Care Reform: Public Health Lessons. *Bull. World Health Organ.* **2018**, *96*, 731. [CrossRef]
43. Atzeni, M.; Carta, M.G.; Primavera, D.; Aviles Gonzales, C.I.; Galletta, M.; Marchegiani, S.; Carboni, G.; Sancassiani, F.; Nonnis, M.; Urban, A.; et al. Reliability and Factor Structure of the Well-Being and Respect for Human Rights Questionnaire in Measuring Caregivers' Perception. *Clin. Pract. Epidemiol. Ment. Health* **2024**, *20*, e17450179310030. [CrossRef]
44. Agenas—Agenzia Nazionale per i Servizi Sanitari Regionali—AGENAS. Available online: <https://www.agenas.gov.it/> (accessed on 3 October 2025).
45. Redazione Gli Infermieri Italiani Pagati Meno Della Media Europea, non Valorizzati e Troppo Pochi. Available online: <https://www.nurse24.it/infermiere/attualita-infermieri/gli-infermieri-italiani-pagati-meno-della-media-europea-non-valorizzati-e-troppo-pochi.html> (accessed on 3 October 2025).
46. Carta, M.G.; Angermeyer, M.C.; Holzinger, A. Mental Health Care in Italy: Basaglia's Ashes in the Wind of the Crisis of the Last Decade. *Int. J. Soc. Psychiatry* **2020**, *66*, 321–330. [CrossRef]
47. Carta, M.G.; Angermeyer, M.C.; Sancassiani, F.; Tuligi, F.; Pirastu, R.; Pisano, A.; Pintus, E.; Mellino, G.; Pintus, M.; Pisanu, E.; et al. A Follow-up on Patients with Severe Mental Disorders in Sardinia after Two Changes in Regional Policies: Poor Resources Still Correlate with Poor Outcomes. *BMC Psychiatry* **2013**, *13*, 333. [CrossRef]
48. Hawamdeh, S.; Moussa, F.L.; Al-Rawashdeh, S.; Hawamdih, S.A.; Moussa, M.L. Illness Anxiety Disorder and Distress among Female Medical and Nursing Students. *Clin. Pract. Epidemiol. Ment. Health* **2023**, *19*, e17450179277976. [CrossRef]
49. Carta, M.G.; Tondo, L.; Balestrieri, M.; Caraci, F.; Dell'osso, L.; Di Sciascio, G.; Faravelli, C.; Hardoy, M.C.; Lecca, M.E.; Moro, M.F.; et al. Sub-Threshold Depression and Antidepressants Use in a Community Sample: Searching Anxiety and Finding Bipolar Disorder. *BMC Psychiatry* **2011**, *11*, 164. [CrossRef] [PubMed]
50. Carta, M.G.; Fornaro, M.; Primavera, D.; Nardi, A.E.; Karam, E. Dysregulation of Mood, Energy, and Social Rhythms Syndrome (DYMERS): A Working Hypothesis. *J. Public Health Res.* **2024**, *13*, 22799036241248022. [CrossRef] [PubMed]
51. Angst, J.; Hochstrasser, B. Recurrent Brief Depression: The Zurich Study. *J. Clin. Psychiatry* **1994**, *55*, 3–9. [PubMed]
52. Pezawas, L.; Angst, J.; Gamma, A.; Ajdacic, V.; Eich, D.; Rössler, W. Recurrent Brief Depression--Past and Future. *Prog. Neuro-psychopharmacol. Biol. Psychiatry* **2003**, *27*, 75–83. [CrossRef]
53. Van Os, J.; Scheepers, F.; Milo, M.; Ockeloen, G.; Guloksuz, S.; Delespaul, P. "It Has to Be Better, Otherwise We Will Get Stuck." A Review of Novel Directions for Mental Health Reform and Introducing Pilot Work in the Netherlands. *Clin. Pract. Epidemiol. Ment. Health* **2023**, *19*, e17450179271206. [CrossRef]

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